

Troy University

Preceptor Information Form (FNP)

Revised 10/24/2013

Students: Please complete **entirely** and return to your instructor. This form will **not** be processed if not complete. **Type in information.** Submit as a Word document attached to an email to your clinical faculty*.

Course Number: _____ NSG 6613 Advanced Health Assessment Preceptorship
(Check one) _____ NSG 6666 Primary Care I Preceptorship
_____ NSG 6668 Primary Care II Preceptorship
_____ NSG 6680 FNP Internship

Semester/Year: Fall _____ Spring _____ Summer _____

Student Name: _____ @troy.edu
First name Last Name email address

Phone: Work () _____ Home () _____ Cell () _____

Agency Name: _____

Address: _____

City, State, Zip: _____

Do you have an RN license in preceptor's state? _____ Have you posted on Certified Background? _____

Contact Person: _____ @ _____
First name Last Name email address

Title: _____ Phone: _____

Preceptor: _____ @ _____
First name Last Name email address

Title: _____ Phone: _____
(MD, NP, PA)

Preceptor Unit: _____

Faculty: _____ Approval: _____

* **Clinical Faculty:** PC- Dr. Whitted kwhitted@troy.edu Troy- Dr. Burns dburns@troy.edu
Mtg: Dr. McHaney dmchaney@troy.edu Dr. Farrell rgfarrell@troy.edu Dr. Riley priley@troy.edu

Office Use Only

Received:

Letter Sent:

Agency Agreement Received: